

# **Burnout and experienced limitations as a therapist**

A qualitative study of Norwegian psychotherapists



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Submitted as a cand.psychol. thesis

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October 2007

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Title: Burnout and experienced limitations as a therapist: A qualitative study of Norwegian psychotherapists

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## ABSTRACT

Little research has been done on how burned out psychotherapists' are experiencing limitations as therapists. The aim of the present study was to do an explorative qualitative analysis of the main limitations experienced as therapist in a strategic sample of burned out Norwegian psychotherapists. A second focus in this study was to investigate how these experienced limitations could shed new light on burnout as a phenomenon.

The data used in the present study was collected as part of a larger international study of the development of psychotherapist, the *International Study of the Development of Psychotherapists* (ISDP), conducted by the *Collaborative Research Network* (CRN). A specific selection of data from the Norwegian contribution to the ISDP study, consisting of Norwegian clinical psychologists working as psychotherapist, was examined.

Five broad categories of limitations were described: *lack of professional efficacy, being to goal oriented, relational difficulties in therapy, basic doubts concerning own qualifications, and difficult work conditions*. Furthermore, the limitations were described as manifested through therapist *own experience* or through experienced *difficulties in the therapeutic work*. The major attribution of these limitations was to reasons associated with internal personal self. Suggestions were also made on how to categorize recent changes reported by the psychotherapists.

Possible ways of understanding the limitations experienced by the burned out psychotherapists were suggested. Based on the discussion of the limitations, theoretical considerations concerning burnout as a phenomenon were given. The results found in this study suggested that internal personal characteristics might be major contributors in the process of burning out. This was discussed in light of Maslach and Leiter's model of burnout and Hallsten's process model of burnout.

## **PREFACE**

And then the day is finally here – the end of a long journey...

First and foremost I would like to thank my supervisor Michael Helge Rønnestad for inspiration, guidance, and encouragement throughout this process. I am also thankful to him both for entrusting me as a research assistant on the DPCCQ-study and for giving me access to the DPCCQ-database.

Thanks also to my friends for being so patient with me during the last months of this process, and to my family for each giving me support in their different ways (a special thanks to my father for supporting me with a new laptop entering the writing phase of the process)

I have chosen to present this work in an article format. The introduction is therefore shorter than what is usual for the cand. psychol. theses. The theory presented, however, is more extensive than what is usually the case in an article – this in order to adjust the format to the demands of a cand. psychol. thesis. As this study is based on a qualitative approach I have further chosen to include a larger part of the theory in the discussion, as the results are to a large degree decisive of which theories are seen as important.

Oslo, October 2007  
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## INTRODUCTION AND THEORETICAL BACKGROUND

To help people who experience major life problems can be very rewarding. Being a helper may be gratifying if clients express their gratitude or you witness them climb over major obstacles in their life with your help. However, not every client show their deepest gratitude, the everyday reality is full of stressful tasks, long work hours, large caseloads, and budget concerns. There is a lot in the professional relationship that can go awry – and when it does it might cause severe difficulties for the helper, the clients, and for the organization wherein these relationships take place. The helper might wear out, become exhausted – the helper might *burn out*.

### The (re)discovery of burnout

According to Johannisson (2006), the burnout phenomenon has its roots all the way back to the Industrial Revolution. Johannisson (2006) describes the “fatigue problem” as a forerunner of the burnout concept, a problem that was a central theme both in scientific communities and the mass media around the year 1900. Burisch (1993) argue that the notion of burnout, or parts of it, has been described in a number of earlier research traditions, including crisis theory, reactance and learned helplessness, and the psychology of conflict. In his opinion, burnout researchers have discovered something that has been known a long time, but not been collectively described under the label of burnout.

As a psychological phenomenon that occurred in the helping professions, burnout was first mentioned by Bradley (1969, in Schaufeli & Enzmann, 1998), when he wrote an article on how to counteract “staff burnout” among probation officers. But it was with the American psychiatrist Herbert Freudenberger’s (1974) influential paper entitled “Staff burn-out” and the work of social psychological researcher Christina Maslach (1976) that the burnout syndrome was established.

The introduction of this burnout syndrome was met with a remarkable reaction, especially from practitioners (Maslach & Schaufeli, 1993). But with roots all the way back to the Industrial Revolution, one can ask oneself why burnout suddenly created such an interest in the late 1970s and up until the present day. Cherniss (1980) states that changes in the social and political climate made people aware of the problem. One of the forces contributing to this, according to Cherniss (ibid.), is a decline in community. He also emphasizes a growing belief that work is the place where one should fulfil oneself. Maslach and Leiter (1997) argue that

the main reason for this interest is that there have been fundamental changes in the workplace and the nature of our jobs, and that the burnout problem's roots lie in economic trends, technology, and management philosophy. Considering psychotherapists in particular, Faber (1990) is of the opinion that an increasing bureaucracy and decreasing autonomy for the therapists might also be contributing to this development. Furthermore he argues that another contributing trend is the increasing numbers of chronic patients that are difficult to treat.

Of the two pioneers mentioned above, Maslach is the one who became the most influential contributor to the understanding of the burnout phenomenon. Maslach was studying how people cope with strong emotional arousal. From her interviews with people working in health care settings some key themes emerged (Maslach, 1993). First, it became clear that emotional experiences played an important role in provision of health care, and that this sometimes can be overwhelming. Practitioners, she says, talked about being emotionally exhausted and drained of all feelings. A second theme in these interviews was what Maslach (1993) termed "detached concern", the difficulties practitioners had with detaching themselves from emotional strain and still maintain concern for their patients. Lastly, a third theme had to do with the self-assessment of professional competence. When the practitioners interpreted the experience of emotional turmoil, it was often seen as a professional failure. When Maslach (1993) happened to describe these results to an attorney, she was made aware of a similar phenomenon occurring among poverty lawyers, called "burnout", a term which she adopted when naming the experiences found in her own interviews.

## **What is burnout?**

### Definitions of burnout

In the three decades of research the concept of burnout has been defined in widely different ways. Initially burnout was a blurred, all-encompassing concept, usually "defined" simply by referring to the symptoms of the syndrome (Schaufeli & Buunk, 2002). As the burnout research became more empirical, mainly two types of definitions of burnout are found in the research literature; *state definitions*, which define burnout in terms of the most characteristic core symptoms of the syndrome; and *process definitions*, which define burnout by describing the dynamic process of burnout. These two types of definitions can be seen as complementary

in that the state definitions describe the end-state of the burnout process (Schaufeli & Enzmann, 1998).

*State definitions.* Probably the most widely used definition of burnout is the three-component model developed by Maslach and Jackson (1981). They define burnout as “a psychological syndrome of emotional exhaustion, depersonalisation, and reduced personal accomplishment that can occur among individuals who work with other people in some capacity” (Maslach, 1993, p.20). After initially claiming that burnout only occurred in occupations where one work directly with recipients, Maslach and colleagues have later expanded the concept beyond those types of occupations (Maslach & Leiter, 1997). Their redefinition includes three more general dimensions of burnout: *exhaustion*, referring to feelings of being emotionally overextended and depleted of one’s emotional resources; *depersonalisation/cynicism*, referring to a negative, callous, or excessively detached response to other people; and *reduced personal accomplishment/professional efficacy*, referring to a decline in one’s feelings of competence and successful achievement in one’s work (Maslach, Leiter, & Schaufeli, 2001).

A somewhat similar, but slightly broader definition of burnout is presented by Pines and Aronson (1988). In their view, the burnout concept is a unidimensional concept. They define burnout as “a state of physical, emotional, and mental exhaustion caused by long-term involvement in situations that are emotionally demanding” (Pines & Aronson, 1988, p. 9). Burnout, as defined like this, is believed to also occur outside occupational settings, such as in love and marriage (Pines, 1996).

*Process definitions.* In the early 1980s, one of the first descriptions of the burnout process was proposed by Cherniss (1980a, 1980b). After studying novice professionals in their early career, Cherniss (ibid.) saw burnout as a transactional process. He defined burnout as “a process in which a previously committed professional disengages from his or her work in response to stress and strain experienced in the job” (ibid., p. 18). Furthermore, he proposed a burnout process consisting of three stages: “The first stage involves an imbalance between resources and demand (stress). The second stage is the immediate, short-term emotional response to this imbalance, characterized by feelings of anxiety, tension, fatigue, and exhaustion (strain). The third stage consists of a number of changes in attitude and behaviour, such as a tendency to treat clients in a detached and mechanical fashion or a cynical preoccupation with gratification of one’s own needs (defensive coping)” (ibid. pp. 17-18).

Hallsten (1993) presents a different process definition of burnout. In his view burnout is a certain kind of depression, and, as such, is not a unique phenomenon. The interesting thing about burnout, according to Hallsten, is the etiology. Hallsten (ibid., p.99) defines burnout as “a form of depression that results from the process of burning out, which is a necessary cause of burnout.” In other words, burning out is one way of becoming depressed. Further he assumes that the process of burning out “appear when the enactment of an active, self-definitional role is threatened or disrupted with no alternative role at hand” (ibid. p.99). Hallstens (1993) framework of burning out is based on three contributing factors, namely *vulnerability* (instability of self-image and self-esteem, dependence of self-definitional role enactment and the lack of subsidiary, and the degree of social support outside of the present work domain), *goal orientation* (commitment expressed and effort displayed regarding long-term goals), and *perceived environmental congruency* (perceived personal and organizational competencies/resources and perceived social support). Depending on these three interwoven factors, the process of burning out may eventually result in either exhaustion, fatigue, and depressive episodes, or in more positive outcomes like reorientation and personal restructuring. In Hallstens view, this process can also occur in non-occupational contexts.

### Dimensionality of burnout

As one can see from the different definitions of burnout above, there is still little agreement on the basic definition of burnout. Over the years there has been much debate as to what burnout actually is and how to best conceptualize it, a debate that raises one important question – the dimensionality of the burnout concept. How many dimensions does burnout comprise?

*Three-dimensional model.* As mentioned earlier, the most widely used model of burnout in scholarly research is Maslachs three-dimensional model and accompanying measurement instrument, the Maslach Burnout Inventory (MBI; Schaufeli & Enzmann, 1998). According to this conceptualisation, burnout encompasses the three dimensions of exhaustion, cynicism (depersonalisation), and inefficacy (reduced personal accomplishment; Maslach et al., 2001). These three dimensions also comprise the three scales of the different editions of the MBI: the MBI-Human Services Survey (MBI-HSS), the MBI-Educators Survey (MBI-ES), and the MBI-General Survey (MBI-GS; see Maslach, Jackson, & Leiter, 1996; for latest manual). Considering the factor structure of the MBI, overall, the three-factor structure has been supported across different occupations, nationalities, and editions of the MBI (Aluja,



Blanch, & Garcia, 2005; Bakker, Demerouti, & Schaufeli, 2002; Boles, Dean, Ricks, Short, & Wang, 2000; Hallberg & Sverke, 2004; Schaufeli, Bakker, Hoogduin, Schaap, & Kladler, 2001; Schutte, Toppinen, Kalimo, & Schaufeli, 2000; Taris, Schreurs, & Schaufeli, 1999). Norwegian studies have also found similar findings (Langballe, Falkum, Innstrand, & Aasland, 2006; Richardsen & Martinussen, 2004; 2005). Schaufeli and Enzmann (1998, p.54) conclude their review of the statistical properties of the MBI with that “the factorial validity and the convergent validity as well as the reliability of the instrument are quite encouraging.”

*Two-dimensional model.* Several authors, however, have suggested that a two-factor model of burnout is more fitting. Kalliath and colleagues (2000) found in their study of the MBI that of the three factors, emotional exhaustion was the most robust, followed by depersonalisation, while the personal accomplishment component seemed to perform weakly. Other studies have suggested that the personal accomplishment component develops in parallel with the emotional exhaustion component (Leiter, 1993; Lee & Ashforth, 1996), and that it might be better conceptualized as a personality characteristic similar to self-efficacy rather than a symptom of burnout (Cordes & Dougherty, 1993). It has also been shown that the personal accomplishment factor is differently related to a number of basic organizational outcomes than the other two factors (Lee & Ashforth, 1996). Together with other empirical evidence (see also Schaufeli et al., 2001), this suggests that exhaustion and depersonalisation (disengagement) constitute the core of burnout, a syndrome that is only loosely related to reduced personal accomplishment (Bakker, Demerouti, & Verbeke, 2004) which plays a less prominent role (Maslach et al., 2001).

*Three dimensions too few?* There are also some researchers who think that three dimensions of burnout are not enough. In his factorial analysis of the MBI, Densten (2001) found a five factor structure of burnout, where the emotional exhaustion factor split up into psychological and somatic strain and the personal accomplishment factor split up in one factor concerning self and one concerning others. The depersonalisation factor remained a single factor.

Still others have suggested a four-dimensional model of burnout. Salanova and her colleagues (2005) argue that whereas emotional exhaustion is regarded as the basic individual stress component of the syndrome that comes close to an orthodox job strain variable and the personal accomplishment is akin to the concept of efficacy beliefs, this leaves depersonalisation as the most innovative component of burnout. In their investigation of the latter dimension they found that it emerged as two unique burnout dimensions:

*depersonalisation*, distancing directed toward the people with whom one is working; and *cynicism*, distancing directed toward the broader context of the job itself.

### Burnout and similar concepts

The initial “blurriness” of the burnout concept contributed to quite a lot of confusion about the distinctiveness of the concept. The burnout concept has been equated with a large number of other phenomena, among them job stress, job dissatisfaction, depression, low moral, tension, poor mental health, fatigue, and helplessness (Maslach & Schaufeli, 1993). Most of these other concepts are plagued with the same definitional ambiguity as is burnout; establishing sharp boundaries between them would be artificial. Therefore, burnout can only be distinguished from other related concepts in a relative way (Schaufeli & Enzmann, 1998).

Nevertheless, the question remains – is burnout truly a distinctive concept? It would be far beyond the scope of this paper to answer this question for every concept that has been equated with burnout, so the focus here will be on two of the most important: *depression* and *job stress*.

*Burnout and depression.* Many theoretical considerations have been proposed concerning the relationship between burnout and depression. Because of the vagueness of the definitions, many of the proposals on the etiopathogenesis of burnout and its relationship with depression are not verifiable (Iacovides, Fountoulakis, Kaprinis, & Kaprinis, 2003).

Even so, empirical research on discriminant validity of burnout and depression has shown that especially the emotional exhaustion dimension of burnout is related to depression (Schaufeli & Enzmann, 1998). Statistically, burnout and depression seem to be distinct concepts. Although they share appreciable variance, confirmatory factor analysis of the items of burnout and depression scales have shown that these items do not load on the same factor, suggesting that these are related but distinct concepts (Bakker, Schaufeli, Demerouti, Janssen, van der Holst, & Brouwer, 2000; Leiter & Durup, 1994). It has also been suggested that burnout and depression can be distinguished with respect to domain, that is, burnout is considered to be job-related, whereas depression is considered context-free (Bakker et al., 2000; Maslach & Schaufeli, 1993; Warr, 1987).

Moreover, there has been found support for qualitative differences between the processes of burnout and depression (Brenninkmeyer, van Yperen, & Buunk, 2001), and a recent study also found that burnout and depression are differently associated with microinflammation biomarkers (Toker, Shirom, Shapira, Berliner, & Melamed, 2005). It seems,

therefore, fairly reasonable to conclude that the concepts of burnout and depression are related, but not identical concepts.

*Burnout and job stress.* Job stress has been described as “a subjective experience that results from interplay of the objective work environment and the employee’s coping resources” (Schaufeli & Peeters, 2000). As one might notice, this is a description that also could be applied to burnout. In a sense, burnout can be considered as prolonged job stress (Brill, 1984, in Maslach & Schaufeli, 1993; Schaufeli & Peeters, 2000) or as a particular type of job stress (Cordes & Dougherty, 1993). Brill (1984, in Maslach & Schaufeli, 1993) distinguishes between stress and burnout in that stress refers to a temporal adaptation process accompanied by mental and physical symptoms, whereas burnout refers to a breakdown in adaptation accompanied by chronic malfunction. The relative distinction between the two concepts can therefore only be discriminated after the adaptation process has either been successfully performed or resulted in a breakdown and burnout.

In their review of job burnout, Cordes and Dougherty (1993) also point to another distinction between the concepts in that the three-component model of burnout is unique as a stress phenomenon. The emotional exhaustion dimension of burnout is a traditional stress variable, whereas the other two dimensions, depersonalisation and (reduced) personal accomplishment, adds, respectively, a new construct to the stress literature and the assertion that self-evaluations are central to the stress experience.

### **Empirical research on burnout: Correlates and possible causes**

The correlates and possible causes of burnout can be divided into biographical, personality, and organizational characteristics. The most studied biographical characteristics are age, work experience, and gender. Of the personality characteristics the so-called Big Five – dimensions of personality are of particular importance. Of more specific personality characteristics traits like hardiness, coping style, and type A behaviour are of the most frequently studied. Finally, the organizational characteristics typically studied have been workload and time pressure, role conflict and role ambiguity, and social support.

### Biographical characteristics

Age is constantly found to be related to burnout. Younger individuals often report higher levels of burnout than older individuals. The same seems true for length of work experience. In other words, burnout seems to be a phenomenon that occurs rather early in the career (Cordes & Dougherty, 1993; Schaufeli & Enzmann, 1998). Similar results have been found in studies of clinical psychologists (Ackerley, Burnell, Holder, & Kardek, 1988; Rupert & Morgan, 2005). But it has to be noted that these findings might be a result of the so-called “healthy worker effect”, in that burned out workers are more likely to leave their jobs, and that the remaining older and more experienced workers have found ways of coping with their problems at work and therefore remain relatively healthy (Schaufeli & Buunk, 2002).

The relationship of burnout with gender is not as clear-cut as that with age and work experience. Some studies show higher burnout for women, others higher for men, and still others no overall differences (Maslach et al., 2001). The one small but significant difference that often is found is that males often score higher on the cynicism dimension and a tendency for women to score slightly higher on exhaustion (Schaufeli & Enzmann, 1998). Studies of clinical psychologists have also reported no gender differences (e.g. Ackerley et al., 1988; Raquepaw & Miller, 1989), but recently Rupert and Morgan (2005) found some indications of gender differences existing within different work settings that were unnoticeable when men and women were compared across all work settings. But these results have only been partially replicated (Rupert & Kent, 2007).

### Personality characteristics

Research on the so-called Big Five factors of personality (McCrae & John, 1992) has shown that especially *neuroticism* is related to burnout. This factor has been found to be a predictor of all three dimensions of burnout (Bakker, Van Der Zee, Lewig, & Dollard, 2006; Goddard, Patton, and Creed, 2004, Kokkins, 2007). Typically, studies shows that neurotic individuals are more likely to report feelings of emotional exhaustion, lower levels of personal accomplishment, and tendencies toward depersonalisation (Lingard, 2003; Zellars et al., 2000). *Extraversion*, has also been found to be a consistent predictor of burnout. It seems like the personal interactions among extraverts and their optimism and self-confidence may counteract depersonalisation and increase feelings of personal accomplishment (Bakker et al., 2006). Other studies have found that extraversion are negatively associated with emotional exhaustion (e.g. Eastburg, Williamson, Gorsuch, & Ridley, 1994; Michielsen, Willemsen,

Croon, De Vries, & Van Heck, 2004), negatively associated with depersonalisation (Zellars et al., 2000), and positively associated with personal accomplishment (Bühler & Land, 2003, Eastburg et al., 1994; Zellars et al., 2000). The remaining three Big Five factors of personality have also been found to be related to burnout, but these results are somewhat contradictory. However, Kokkins (2007) recently found results indicating that *conscientiousness* may be a key personality trait associated with depersonalisation and personal accomplishment. In this study, teachers scoring low on conscientiousness demonstrated higher levels of depersonalisation, whereas those scoring high on conscientiousness were more likely to exhibit higher levels of personal accomplishment.

By definition, *hardiness* is a concept of three component: challenge (openness to change and problem solving); commitment (a feeling of involvement); and control (a sense of personal influence; Simoni & Paterson, 1997). This “hardy personality” have been found to be related to all three burnout dimensions in that a hardy individual are less exhausted, less depersonalized, and have stronger feelings of personal accomplishment (Schaufeli & Enzmann, 1998; Simoni & Paterson, 1997). This indicates that a hardy personality may function as a buffer against burnout, or put differently, that lack of hardiness may make a person vulnerable to experiencing burnout symptoms.

A trait related to hardiness, *coping style* (when facing stressful events), has also been found to be related to burnout. Different coping strategies can be categorized into four categories: *active coping strategies*, which are directed toward the source of stress; *inactive coping strategies*, which involve avoidance or denial of the source of stress; *direct coping*, applied outwardly to the environmental source of stress; and *indirect coping*, applied inwardly to one’s own attitudes, emotions, and behaviours (Simoni & Paterson, 1997). A review of twelve studies showed that those who are burnt-out cope with stress in an inactive way, whereas active coping is associated with less burnout (Enzmann, 1996, in Schaufeli & Enzmann, 1998). In addition to the effects of hardiness mentioned above, Simoni and Paterson (1997) also found that the individuals using direct-active coping had the lowest burnout scores and that the individuals using direct-inactive coping had the highest. Similar results were recently also found among Spanish human service practitioners (Jenaro, Flores, & Arias, 2007).

Type A behaviour has been linked to burnout in several studies, especially the exhaustion dimension (Maslach et al., 2001; Schaufeli & Enzmann, 1998). *Type A behaviour* is used to describe patterns of behaviour characterized by high ambition, competition, time pressure, impatience, hostility, and excessive need for control (Maslach et al., 2001; Hallberg,

Johansson, & Schaufeli, 2007). Jamal and Baba (2001) found in their study a positive correlation between global type A behaviour and burnout. In a recent study, Hallberg and her colleagues (2007), following more recent research, investigated the associations of two principal dimensions of type A behaviour, achievement striving and irritability/impatience, with burnout and its positive antithesis work engagement. Their study suggests that the achievement striving dimension of type A behaviour is a “non-toxic” component, while type A individuals reporting more frequent irritability/impatience also reported more frequent burnout complaints.

### Organizational characteristics

According to Maslach and Leiter (1997), the causes of burnout lie more in the job environment than in the individual. They argue that the causes of burnout can be traced to six mismatches between people and their jobs: work overload, lack of control, insufficient reward, breakdown in community, absences of fairness, and conflicting values. Even though there has been a paucity of research testing this model, Maslach *et al.* (2001) argue that experienced workload and time pressure have been found to be strongly and consistently related to burnout, particularly the exhaustion dimension. A meta-analytic study of burnout found that, on average, workload and time pressure share 42% and 25% of variance with emotional exhaustion, respectively (Lee & Ashforth, 1996). The relationships with both the other two MBI-dimensions have been found much weaker. But these results may not be as straight forward as they seem. In their extensive review of burnout, Schaufeli and Enzmann (1998) note that the high correlation with workload may be because a considerable overlap in item content exists. Workload is often operationalized in terms of experienced strain that overlap considerably especially with emotional exhaustion.

Other organizational characteristics that have been frequently studied are *role conflict* and *role ambiguity*. Role conflict occur when one has to meet conflicting demands at work, while role ambiguity occur when one has inadequate information on how to do the job well. According to Schaufeli and Enzmann (1998) role conflict and role ambiguity correlate moderately to highly with burnout. A meta-analytic study of 49 studies concerning role conflict and 38 studies concerning showed that role conflict shares 24% of variance with emotional exhaustion, 13% with depersonalization, and only 2% with personal accomplishment. For role ambiguity, the numbers where 14%, 8%, and 10%, respectively (Pfennig & Hüsch, 1994; in Schaufeli & Enzmann, 1998).

Research on the relationship of social support with burnout has given clear evidence for a positive relationship between lack of social support and burnout (Schaufeli & Enzmann, 1998). Especially lack of support from supervisors seems important. In their meta-analytic study, Lee and Ashforth (1996) found that support from supervisors explain 14%, 6%, and 2% of emotional exhaustion, depersonalization, and personal accomplishment, respectively, whereas the percentages for support from co-workers were 5%, 5%, and 2%, respectively. Concerning social support from supervisors, a recent study found that burnout was best predicted by dissatisfaction with emotional support received from supervisors (Prins et al., 2007). In addition, dissatisfaction with appreciative support received from supervisors appeared to have a unique predictive effect on emotional exhaustion. Even though supervisors may seem more essential in the relationship of social support and burnout, Janssen, de Jonge, and Bakker (1999) concluded their study among nurses that limited social support from colleagues is a primary determinant of burnout. High levels of support from co-workers have also been related to lower levels of emotional exhaustion in nurses (Jenkins & Elliott, 2004). Additional support for this is presented in a recent study, where Glasberg, Erikson, and Norberg (2007) found that lack of social support from co-workers was associated with both the emotional exhaustion and the depersonalization dimension of burnout.

### **Therapists' experience of difficulty in practice**

Even though most psychotherapists find conducting psychotherapy enriching and nourishing working as a psychologist might sometimes be a gruelling and demanding task (Norcross, 2000). Freud once described psychotherapy as an “impossible profession”. Surveys have found that over 90% of psychotherapists report having experienced emotional problems directly related to their professional therapeutic role (Guy & Liaboe, 1986). On study also revealed that over 74% of the psychologists reported feeling personal distress during the previous three years (Guy, Poelstra, & Stark, 1989). Considering that the therapist's personality factors has been found to be a predominant factor in successful therapy (Lambert, 1989), there has been surprisingly few studies exploring therapist's experiences of limitations and difficulties in therapy.

One exception is the work of Thomas Schröder (1998), who has carried out an extensive study investigating what makes therapy difficult, from the view of the therapists. According to Schröder, therapist difficulties can be divided into three types of difficulties:

*transient*, based on competency deficits; *paradigmatic*, based on therapists' enduring personal characteristics; and *situational*, based on features of patients or circumstances (Schröder & Davis, 2004). Transient difficulties are thought of as connected with perceived deficits in the knowledge or technical repertoire of the therapist experiencing the difficulties. These are seen as temporary and do not reflect stable personal characteristics. Paradigmatic difficulties, however, are described as typical of the individual therapists rather than of situations or developmental levels. These difficulties are seen as enduring characteristics of the therapist experiencing them, such as the therapists' personality structures or significant intrapsychic conflicts, or interpersonal features. Finally, situational difficulties are described as either deficits in knowledge or personal characteristics, but rather as difficulties attributed to external factors, such as problematic circumstances or patients experienced as problematic. These limitations are viewed as inherent in the situations encountered by the therapists.

Another exception is a recent study by Thériault and Gazzola (2005). They investigated therapists' feelings of incompetence (FOI) in experienced therapist and found that these existed on a continuum of intensity, ranging from *inadequacy*, through *insecurity*, to *incompetence proper*. The mildest category, inadequacy, often resulted from professional issues such as questioning one's knowledge, skills, training, and ability to help the client on a general level. This category also included human fallibility. This type of feelings of incompetence was viewed as permissible and even positive by the respondents when it provided an opportunity for enrichment. In the middle of the continuum, the category labelled insecurity described more intense feelings of incompetence. These types of feelings were related to the therapists' self-confidence in their professional roles and their faith in the process of therapy. Self-doubts in this category had their basis in aspects like relationship issues and communication obstacles, leading the therapists' doubts towards more central elements of self. Thériault and Gazzola's (ibid) last category, incompetence proper, encompassed the most intense, uncomfortable, and damaging feelings of incompetence. These feelings arose from personal issues and the self-doubts targeted core elements of the self. This type of FOIs was more pervasive and difficult to process.

### **The present study**

Because of the personal nature of their work and the client with whom they work, clinical psychologists working as psychotherapists are seen as being at risk for burnout. The costs of burnout among these human service professionals are potentially high, involving not only the



personal toll on the individual who experience burnout, but also high costs to the organizations in which they work from employee turnover and possible harm to clients as a result of decline in the quality of the service provided by the burned-out professional.

Research on burnout involving this group of professionals has been limited. The little research that has been done has primarily quantitatively investigated relationships between burnout and global work characteristics and demographical variables. A fuller understanding of what are the difficulties burned out psychotherapists are struggling with in therapy seems to be lacking. With the potentially high cost of burnout in mind, an explorative study of this group of professionals and their experienced limitations in therapy seems desirable. This is therefore the primary aim of the present study.

Another reason for studying limitations reported by this group is that the difficulties these burned out psychotherapists are experiencing in their work might also shed some new light on the concept of burnout in itself. Burnout is believed to have specific antecedents or causes both in the individual and in the work environment. Finding out what contributes to the difficulties experienced by these psychotherapists and how these difficulties might contribute to burnout can therefore be an important side-effect of this study.

My focus in the present study can, therefore, be seen as two-fold. First, I want to explore what are the limitations these burned out psychotherapists are experiencing in their present work per se. Secondly, I want to investigate how these limitations might have contributed to the process of burning out and how this can be related to burnout as a phenomenon.

### *Research questions*

- What are the most problematic experienced limitations perceived by burned out psychotherapist?
- How can the experienced limitations found in this study shed new light on burnout as a phenomenon?

## **METHOD**

This work is based upon a combination of quantitative and qualitative procedures. First, the sample, that will be describe more thoroughly below, was selected based on the pattern of

burnout scores. The answers given by the respondents in this sample on four open-ended questions concerning experienced limitations as a therapist were then analysed qualitatively.

### **Data collection and procedure**

The data used in the present study was collected as part of a larger international study of the development of psychotherapist, the *International Study of the Development of Psychotherapists* (ISDP), conducted by the *Collaborative Research Network* (CRN), a subgroup within the *Society of Psychotherapy Research* (SPR). A large database containing data from all over the world, gathered from more than 7000 psychotherapists of various professions and theoretical orientations at present, is being built using the specifically designed instrument, the *Development of Psychotherapists Common Core Questionnaire* (DPCCQ; see Orlinsky et al., 1999; Orlinsky & Rønnestad, 2005 for a detailed description of the research program).

In this work, a specific selection of data from the Norwegian contribution to the study was examined, namely data collected from Norwegian clinical psychologists working as psychotherapist. The data were collected by means of a postal survey, in which members of the Norwegian Psychological Association (NPA) were invited to participate. Data used in this work has been collected in several waves, the first in 1996 and the last in 2005/2006. To ensure anonymity, the filled-in questionnaires did not contain names or addresses, but a self-made six letter code constructed by the therapists themselves.

### **Measures**

The Development of Psychotherapists Common Core Questionnaire (DPCCQ; Orlinsky et al., 1999), by which the data in the present study was collected, is a 20 page comprehensive structured survey package consisting of 370 items from nine different sections containing information on a large variety of experiences of therapists assumed to be of relevance to their professional development. The main purpose of the various questionnaires is to better understand the nature of therapists' professional development or stagnation.

The questionnaires tap, for instance, therapeutic skills, theoretical orientation, attitudes towards and experiences with personal therapy, viewpoints on therapeutic goals, in-session feelings of therapy, practice characteristics, experiences of difficulties, coping skills, interpersonal styles with clients and personal and private-life characteristics. Most of the

questions take the form of fixed responses on 4-6 point Likert-type scales, but there are also a number of open-ended questions, as well as qualitative mini-essay questions. Among these were the four open-ended questions analysed qualitatively in this work, and these questions were:

1. What do you feel is your most problematic limitation as a therapist?
2. How is this limitation manifested in your current work?
3. To what do you attribute this limitation
4. Has this limitation changed in the recent past? (And if so, to what do you attribute the change?)

In addition to DPCCQ, the psychotherapists in the Norwegian sample were asked to fill out a Norwegian translation of Maslach Burnout Inventory-Human Service Survey (MBI-HSS; Richardsen & Martinussen, 2004). The MBI consists of 22 items loading on the three burnout dimensions emotional exhaustion, depersonalisation, and (lack of) personal accomplishment. All the items take the form of fixed responses on 7 point Likert-type scale (for more on the statistical qualities of MBI-HSS, see Richardsen and Martinussen, 2004)

### **Sample**

The sample was selected from a total of 1122 Norwegian clinical psychologists working as psychotherapists who had answered the Norwegian translation of DPCCQ. As it has not been possible to identify which Norwegian psychologists are working as psychotherapists, I can not clearly assess how representative the total sample is. However, the total sample consists of a substantial proportion of psychology licensed Norwegian psychotherapists. Out of these psychotherapists, 1011 had answers that made it possible to locate their scores on the three dimensions of burnout; emotional exhaustion, depersonalization, and personal accomplishment. Based on these scores, a strategic sample of the psychotherapists who had the highest MBI burnout scores was selected. Following how the MBI-HSS normative sample has been divided (Maslach et al., 1996), this was done by computing each respondent's mean scores on each of the three burnout dimension in the MBI, and then selecting the respondents that scored on the highest 1/3 on each burnout dimension (inverted scores for Personal Accomplishment). This sample could then be characterized as what the test authors of the MBI have termed 'a high degree of burnout' (Maslach et al., 1996). This procedure resulted in

a sample of 71 psychotherapists. This sample included 60% women and 40% men, and had a mean age of just over 39 years, the youngest being 26½ years and the oldest being 69 years old. The mean duration of total practice for this sample was 8,7 years, ranging from 0,67 years to 45 years of practice. Finally, the sample included three equally sized career cohorts (Orlinsky & Rønnestad, 2005); 1/3 could be characterized as *novices* (0 – 3,5 years of practice); 1/3 could be characterized as *graduates* (3,5 – 7 years of practice); and 1/3 could be characterized as *established, seasoned, or senior* (7 years or longer practice). Of the 71 psychotherapists, 60 had answered the four open-ended questions in a way that made them suitable for the further qualitative analysis, and these 60 psychotherapists therefore became the final strategic sample.

### **Analyses**

The qualitative analyses in this work had two main sources of inspiration. The principles of *phenomenological research methods* (Groenewald, 2004) were seen as a constructive approach for the initial phases of the analyses. Also, since there are relatively few studies concerning psychotherapists' experienced limitations in therapy, this was seen as an appropriate method for getting to know and explore the meanings of the data, and for answering the first research question. When the analytic process turned to structuring of data in domains and categories the analyses became more inspired by the principal and procedures of *consensual qualitative research* (CQR; Hill, Thompson, & Williams, 1997; Hill et al., 2005). Due to a lack of resources, it was not possible to have a team work out consensus about the data structure, as the ideal according to the CQR principals would be. Therefore, my supervisor Michael Helge Rønnestad, served both as a team member and as an auditor in this later part of the analytic process, a combination of roles that has been described in the work of Nerdrum and Rønnestad (2002). In addition, I also had several discussions in this phase with a PhD-student, Ellen Langballe, who were about to finalize her dissertation on subject of burnout. Taken together, I believe this could balance the lack of consensual validation in the construction of the data structure.

After the initial step, the method decided on were largely guided by the themes that started to come out of the material and how they made me associate. The analyses were decided to be divided into six steps, thoroughly going through the entire material several times in each and every step. These six steps included:

### Step 1: Getting to know the material

The starting point of the analyses was to thoroughly read through the answers, trying to keep a broad focus and an as open mind as possible to what the material could tell me. In this initial step I tried to find what seemed to be the most important themes in each therapist's answers to the four questions. In doing this, I tried to simply uncritically write down, on face value, whatever associations that came to mind. Even though sometimes hard, I tried not to interpret or judge any of the statements at this stage, and simply stay focused on and write down what I thought to be the meaning or themes in each statement.

At this early stage I felt as though I was a young kid again, who had been given lots of pieces of a jig-saw puzzle by someone who had forgotten to give me the box showing what the end result should look like. My task was to get to know the material and identify each piece of the puzzle. Although I had already gone through quite a lot of burnout literature, I tried not to make interpretations based on theoretical knowledge at this stage of the process. Even so, theoretical or interpretive association popped up on occasions. These were then written down and sought to put aside until later in the process. This initial stage of the analytic process is comparable to what in phenomenological research methodology has been called "bracketing out" or "epoché", a process in which the researcher's own presuppositions are put aside and the researcher's meaning and interpretations or theoretical concepts are not allowed to enter the unique world of the respondent (Groenewald, 2004).

### Step 2: Rephrasing statements

In getting to know the material, my search for the meaning and themes in the different statements often led me to rephrase the answers in different ways in an attempt to get a deeper understand of the experience of each individual voice. This became the second step of my analyses. Illustrated through the jig-saw puzzle image, these two first steps included having a close look at each individual piece of the puzzle and trying to identify the colour, size, and shape of the individual pieces.

### Step 3: Descriptive Domains

In this third step, I collected and worked through all the themes and association found in the first two steps. Each one of them was written down on a paper card, resulting in a total of over 250 cards divided between the four questions. All these cards represented my descriptive domains, which also became the basis for the categorization process in the next step. The domains found in this material were attempts at describing what each individual voice were

saying without comparing them with each other or trying to group them in categories. The process of finding these domains can be compared to what is referred to as “phenomenological reduction” in phenomenological research (Groenewald, 2004). Most domains were found for the three first questions. The reason for this was (most likely) that quite a few respondents had answered the last question simply by stating that they had experienced no change in the recent past and given no further explanation for this.

In my jig-saw puzzle I now had reached a stage where I felt that the pieces had been identified, and it was time to try to systematize the pieces and get an idea of what the picture would look like in the end.

#### Step 4: Categorization

In this step of the analyses I left, for the first and only time, the focus on the individual level behind and went searching for clusters of themes given by the psychotherapists in the material. This search for common themes or categories was by far the most time consuming, and not to mention space consuming, part of the process. All the domain cards were laid out on a large table, the cards for one question at the time, and a lot of grouping and regrouping of the domains took place in this process. Some of the descriptive domains were rather easy to group, as they were quite short and conclusive, often being the same or similar word, while others were more inconclusive and harder to group.

I soon realized that the categories that came out of this process were far from final. Going through the answers seen as belonging to the categories, or describing the categories themselves, frequently led to reconstructions or subdivisions of the categories. In other words, the categories were revised several times, all the time seeking a more meaningful way of understanding and describing the material.

At this stage of the analyses, we were inspired by the principal of consensual qualitative research (CQR; Hill et al., 2005). As mentioned above, we did not have enough resources to have an entire team working out the categories. In this work, therefore, I was going through the material and extracting categories, while my supervisor Michael Helge Rønnestad, served both as a team member and as the auditor. It was also at this point I had the PhD-student as a discussion partner on several occasions, as a mean of preventing premature closure concerning the categories.

This fourth step gave me clearer ideas of what the jig-saw puzzle might look like in the end. The categories indicated what the picture in the end should contain, and also gave

some clues about where to put things. The next challenge at this point was to figure out how these distinct parts of the puzzle fitted together.

#### Step 5: Individual summaries

After finding the different categories for each question, this next step brought me back to focus on the individuals. At this step, individual summaries based on the categories were made for every psychotherapist in the sample. This was seen as a helpful strategy for facilitating the sixth and final step of the analyses, the search for connections between categories.

#### Step 6: Connecting the individual summaries

In this final step of the analyses, the focus was on whether any special connection could be found between the categories. This was done by going through the individual summaries of the respondents falling into each category and see whether they had any common themes or answers. This step can be compared to what has been termed “charting the results” in CQR methodology (Hill et al., 2005).

Finally I felt I had the finished jig-saw puzzle laid out on the table in front of me (which I, at this point, actually had quite literally). In the next sections I will first describe what this picture look like, before I then move on to discuss how this piece of art can be interpreted.

## **RESULTS**

In this section, the different broad categories and subcategories found in the analyses of each of the four open-ended questions will first be described separately. Even though most of the answers fall into only one broad category or subcategory, the categories are not necessarily seen as mutually excluding. Thereafter, I will turn to the findings from the final step of the analyses and describe what is seen as the most important clusters of dynamics that evolved from the individual summaries that were made based on the categories found in the material.

### **Question Number One: Self-experienced Most Problematic Limitation**

The answers given to the first question were differentiated into five broad categories: lack of professional efficacy, being too goal oriented, relational difficulties in therapy, basic doubt concerning own qualifications, and difficult work conditions. The former three categories were further divided into subcategories.

#### **I: Lack of Professional Efficacy**

All the answers in this broad category refer to limitations experienced as doubts concerning some specific part of their professional life. This category is divided into three subcategories; Lack of experience; Lack of knowledge or skills; and Lack of structure in therapy.

##### *1. Lack of Experience*

The respondents in this category indicate that their main limitations are a lack of experience as a therapist. Most of the respondents express themselves in rather short and general terms, as one says: “Too little experience”, or as another says: “Lacking experience”. A few others also specify more specific areas they feel they lack experience in. An example of these answers is: “Lack of experience when it comes to pointing out and utilize the processes going on between therapist and patient.”

##### *2. Lack of Knowledge or Skills*

In this category, the answers describe having difficulties in knowing what to do in therapy and not having adequate therapeutic techniques. Some of the respondents indicate a primary lack of theoretical knowledge, while others feel their main limitation is lacking therapeutic skills. Examples of these are, respectively: “Too little specialized knowledge” and “Lacking skills as a therapist.” Some of the answers also seem to reflect that the respondents feel they are lacking both knowledge and skills. As one respondent says: “Too little theoretical and clinical knowledge about therapy as a tool.”

##### *3. Lack of Structure in Therapy*

The answers in this category indicate that these psychotherapists feel they have some difficulties maintain a broad view of the therapy, that they lose themselves in the details. One respondent says: “It feels difficult to find the common denominator or the prioritized sequence of focus.” Other answers seem to reflect that the respondents falling into this category feel they don’t work systematically enough and have difficulties maintaining a structured therapy, as one respondent says: “Difficulties following a firm structure.”



## II: Being too goal oriented

This category is characterized by answers reflecting a lack of delimitation according to demands they put on their patients and an overly eagerness for seeing results in the therapeutic process. This category is divided into two subcategories; Impatience; and The need to see progress.

### *1. Impatience*

This category includes answers that typically are very short or only one word. The respondents in this category describe general feelings of impatience. The typical answer is simply “Impatience”, but some also specify this more, as one respondent says: “An impatience with the least resourceful patients, and the least motivated.”

### *2. The Need to See Progress*

The answers in this category are closely linked to those in the previous category in that they also indicate some underlying feelings of impatience, but they specify this feeling by describing a need to see some results of what they do, or see some kind of progress in their work. One answer categorized in this group is: “That I am goal oriented, want to see results of what I do.”

## III: Relational Difficulties in Therapy

These answers all include a perception of difficulties mainly being centred in the interactions with the patients. This broad category is further divided into two subgroups; Regulation of emotional distance; and Dysfunctional emotional reactions in therapy.

### *1. Regulation of emotional distance*

These respondents all share an experience of having difficulties with the self-other-differentiation. The majority of them describe some kind of difficulty with differentiating themselves from the emotions of their patients. One respondent says: “Hard to delimit myself when it comes to the patient’s emotional problems – can become very affected by the patient’s condition. Hard to have an independent position to the patient.” Other difficulties describe in this category are low tolerance for strong emotions in the patients, for own and patients’ unpleasant affects and a fear of confronting their patients. One respondent express this by saying he has a hard time with “confrontation – resulting in shared unpleasant feelings.” Some respondent in this category also seem to have difficulties with handling transference and countertransference. An example of these is: “Too involved. Difficulties with

negative transference (handling this constructively).” The underlying theme in all these answers is difficulties in finding the adequate emotional distance to the patients.

## *2. Dysfunctional emotional reactions in therapy*

All the respondents in this category express some difficulties with their emotional expression in therapy. Some say they easily get bored or irritable, others feel they are too kind. One of the respondents also says she “appear frightening to many patients.”

## IV: Basic Doubt Concerning Own Qualifications

The respondents falling into this broad category all consider their main limitation to be something internal within themselves. One can describe their attitudes towards themselves as a basic doubt in themselves or as a basic doubt concerning their own abilities as a therapist. Examples of the first way of answering are: “Fear of not being good enough” and “Sometimes doubt concerning the significance of own work.” The other way of answering can be exemplified by the following answers: “Doubts on own ability as a psychologist” and “Uncertainty concerning the role as a therapist.” Several of the respondents’ answers do also seem to reflect that these doubts have their roots in the psychotherapists’ own experience or personal issues, as one respondent puts it: “That I occasionally can have some anxiety myself and that I therefore for shorter periods can become a little distanced.”

## V: Difficult Work Conditions

Contrary to the respondents in the categories described above, the respondents in this broad category refer to their main limitations as outside themselves, in their work settings. These respondents refer to characteristics of their work, like one respondent saying that her main limitation is “Many complicated cases.” Others refer to the broader context of their work setting, exemplified by one respondent saying her limitation as a psychotherapist is: “All the time I spend attending meetings concerning the administration of team.” The common thing in all these answers is that they all refer to limitations external to themselves that seem to be outside of their control.

## **Question Number Two: Manifestation of Limitations in Current Work**

The psychotherapists' answers to the second question were divided into two broad categories; Manifested through own experience; and Manifested as difficulties in the therapeutic work. The former broad category was further divided into three subcategories, while the latter was divided into two subcategories.

### I. Manifested Through Own Experience

This first broad category includes answers that all seem to reflect manifestations of the limitation as an internal process going on inside the psychotherapists' mind. These respondents all describe difficult feelings experienced in connection with their work as a psychotherapist. This broad category is divided into three subcategories; Uncertainty and carefulness; Exhaustion and resignation; and Disengagement.

#### *1. Uncertainty and Carefulness*

The respondents falling into this category all seem to share feelings of being uncertain or careful with reference to different aspects of their therapeutic work. Some respondents describe general feelings of uncertainty and carefulness, while others express a doubt regarding more specific areas of their work, like whether or not they are working in the right way or uncertainty when confronting patients. A typical example of the more general answers is: "Uncertainty regarding my own way of working." The more specified answer can be exemplified with the following answer: "Uncertain when it comes to confronting patients."

#### *2. Exhaustion and resignation*

This group of answers reflects feelings of having to spend too much energy on their work, ending up feeling depleted of energy, tired, or exhausted. One respondent express it like this: "Feeling of being overwhelmed, exhausted, and powerless. A desire to get away." These respondents all seem to have crossed some line where their limitations give them so many difficulties that the manifestation of their limitations is a desire for giving up, or that they already have done so. They describe experiences of being dispirited and that they can be reluctant towards treating specific groups of patients. One respondent says she "Choose not to take cases concerning heavy, chronic conditions." This group seems to experience a doubt whether they want to continue working as a therapist, and several respondents express thoughts about giving up working as a therapist. One psychotherapist says her limitation "often gives me thoughts about not wanting to do psychotherapy."

### *3. Disengagement*

These respondents are characterized by manifestations of their limitations as distancing themselves from their patients. They describe difficulties paying attention, a declining engagement, and sometimes being somewhat absent-minded. An illustrative example of this category is: “Maybe a little absent-minded and that some maybe notices that I struggle a little to get involved.”

## II. Manifested as Difficulties in the Therapeutic Work

The respondents falling into this broad category all seem to struggle with some aspects of their therapeutic work. This broad category is further divided into two subcategories: Inadequate structuring of therapy; and Avoidant behaviour in therapy.

### *1. Inadequate Structuring of Therapy*

The psychotherapists falling into this category all have in common a feeling that their limitation is manifested as a lack of the ability to work systematically throughout their therapies. They describe themselves as being too quick, too diffuse, or having trouble taking the control. One of these respondents says that she “Becomes a little diffuse and a little too ‘kind’ in therapy with people that need clarity and boundaries.” Another respondent says: “Too many themes can be brought up, with the consequence that important elements can get too little attention and time.”

### *2. Avoidant Behaviour in Therapy*

This second category of answers all seem to reflect that these respondents have not yet found adequate ways of handling difficulties they encounter in therapy, and therefore have resolved to avoid what they find difficult. They describe experiences of delaying things they think is important, or simply just avoid them because they believe doing them might cause some pain they don’t think they can handle. A typical answer for this category is: “Can avoid important themes because I want to avoid this pain.”

## **Question Number Three: Attribution of limitations**

The analyses of the respondents’ answers to the third question resulted in three broad categories: Attribution to internal professional self; Attribution to internal personal self; and Attribution to external work conditions. The second category was further divided into two subcategories. The distinction was based on to what degree the answers were reflecting an

internalisation or externalisation of the attribution of the limitation. Concerning internalisation of the attribution, a distinction were also made based on whether the answers referred to aspects of the role as a professional or referred to a more personal self.

### I. Attribution to Internal Professional Self

The respondents in this first broad category all have in common answers reflecting that the reason for their limitation is linked more to their role as psychotherapists than it is to them as persons. In general, the answers are linked to two aspects of the professional life. The first group of answers refers to duration of practice as the cause of the limitation, the main cause being a lack of experience as a therapist. A typical answer exemplifying these answers is: “Lacking experience in clinical work.” The second group of answers refer to a lack of knowledge or therapeutic skills as the reason for the main limitation, exemplified by the following answer: “Uncertainty concerning own skills.”

### II. Attribution to Internal Personal Self

The answers in this broad category are characterized by an internalisation of their attributions. They all attribute their main limitations to aspects of their personal self. The category was further divided into two subcategories: Personality or certain abilities; and Personal experience.

#### *1. Personality or Certain Abilities*

This group of answers all shares a common focus on personal variables as the cause of the main limitation. The respondents in this category typically attribute their limitations to aspects of their personal self, either to their personality, to personal characteristics, or to having or lacking certain abilities. Typical answers from these respondents are: “Personal characteristics and lifestyle – I am a quick person who rapidly finishes with the present and want to think forward” and “Personal insecurity and introversion rather than open, more active extroversion.”

#### *2. Personal Experience*

As in the category above, this group also has an internalized attribution of their limitation to aspects of their personal self, but this group of respondents attributes their main limitations to personal experiences they either have had in the past or experiences they are currently going through. The first group of answers often refers to the respondents’ upbringing, childhood

experiences, or earlier interactions between themselves and their environment. The other group of answers refers to problems in the respondents' private life they are going through presently. An example of the first group is: "Own experience from the childhood family." The second group of answers can be exemplified by the following answer: "I have to spend a lot of energy on sorting my private life."

### III. Attribution to External Work Conditions

The respondents falling into this broad category all have in common an externalisation of the cause of their main limitations. These answers refer to aspect of the work setting the respondents are working in. Some of these respondents refer to a lack of time and too much to do as the cause of their limitation, while others attribute their limitations to poor working environment and difficult patient. One respondent simply says: "Too much to do". Another respondent attribute her limitation to: "The work environment and the work system." The answers from many of the respondents in this category also seem to reflect that they experience a lack of control over these external sources, as one respondent puts it: "Too little influence over which clients I have to work with."

## **Question Number Four: Recent Change and Attribution of Change**

Of the four questions, this last question was the easiest to categorize. The respondents differed in whether they had experienced no recent change or had experienced either recent positive or negative change.

### I. Positive Change

Those respondents who expressed that they had experienced recent positive change attributed this to three different causes. One group of respondents attributed this change to interactions with other professionals. The majority of this group mention own personal therapy as the reason for this change, while a few also mention supervision or discussions with colleagues as a reason for this. The second group refers to accumulated experience and knowledge as a source for their positive change. One of the respondents in this second group also adds another reason for his positive change: "Have become older, more experienced, and have better chairs at the office." The third and final group mentions a more general personal

development as reason for their recent positive change. Typically, these respondents refer to having developed certain abilities, have become less afraid, and feel they have better control and insight. One of these respondents talks about going through a personal crisis, and how this has had a positive impact on him, resulting in that “I am more present in the here-and-now.”

## II. Negative Change

Recent negative change is also attributed to three different causes. The first and largest group of answers refers to worse work conditions as the cause of the negative change. These work conditions include the work setting in general, difficult group of patients, and constitutional demands. As one can see, these attributions all refer to external causes for the change. In the other two groups the negative change was attributed to oneself. These two lesser groups attributed the negative change either to having personal issues to deal with, such as somatic illness or family issues, or they attributed the change to a general decline in engagement. An example from this last group of answers is: “A development towards a desire to phase out the therapeutic work (was previously very engaged).”

### **Possible dynamic from the individual summaries**

In this section I will describe the most important clusters of dynamics that evolved from the individual summaries that were made based on the categories found in the material. Table 1 presents the entire set of connections found between the limitations reported by the respondent and the answers given to the other three questions, the descriptions here will therefore only be brief.

As Table 1 (attached Appendix A) is showing us, limitations categorized as *lack of experience* are frequently manifested through *own experience* characterized as *uncertain and careful*, which is also a common manifestation of both limitations categorized as *the need to see progress* and limitations categorized as *difficult work conditions*. A different pattern is found for the limitations categorized as *lack of knowledge or skills*. These limitations are uniquely associated with *inadequate structuring of therapy*. A similar unique pattern can be found between the category of limitations characterized as *regulation of emotional distance* and its frequent manifestation as *avoidant behaviour*.

If we take a closer look at the dynamics between the categories of limitations and to what these limitations are attributed, the most striking pattern is that most of the limitations

mentioned by the psychotherapists, with only two exception, are frequently attributed to *internal personal self*. Most often these attributions are to reasons categorized as *personality or certain abilities*, but rather frequently also to the reasons categorized as *personal experience*. Interestingly, the limitations categorized as *lack of experience* are the only ones that frequently are attributed to *internal professional self*. It is also interesting to note the apparent lack of frequent association between any categories of limitations and *external work conditions*.

Turning to the last column of table 1, two patterns are worth noting. The first is the unique patterns between *difficult work conditions* and *the need to see progress*, and recent change. These are the only two types of limitations that are never associated with *a recent positive change*. The second pattern is that between the limitations categorized under the broad category *lack of professional efficacy* and recent change. With the exception of one respondent falling into the subcategory *lack of structure in therapy*, all the respondent falling into these three subcategories have reported either having *no change*, or, as most of them report, *a recent positive change*.

## DISCUSSION

The aims of the present study were two-fold. The first aim was to conduct a phenomenon-explorative study of limitations experienced by burned out psychotherapists in their therapeutic work. The basis for the discussion of this first research question will be the categories described above, with a main focus on the first open-ended question which addresses the topic of limitations most directly. The categories described in conjunction with the other three questions will mainly serve to clarify and extend the understanding of the limitations. Parallel with this discussion, these findings will be compared to the research literature on burnout.

The second aim was to, through the understanding of the limitations experience by these burned out psychotherapists, reveal some new understanding regarding burnout as a phenomenon. This will be discussed in the latter part of this section.



## Burned out psychotherapists' experienced limitations

### Limitations concerning lack of professional efficacy

This first broad category, *lack of professional efficacy*, concerns what appear to be feelings of incompetence as a therapist. The majority of this group of respondents reports a recent positive change indicating that if these therapists were to acquire more clinical experience, conceptual knowledge, or more therapeutic skills, one would expect these limitations to subside or fade away completely. These limitations therefore seem to be equivalent to what Schröder and Davis (2004) refer to as *transient difficulties*. Such difficulties are described as essentially impermanent in nature and are potentially capable of being remedied through further training and experience, and Schröder and Davis (2004, p. 331) define them as “difficulties in which the situation encountered exposes deficiencies in the therapist’s knowledge, technical skills, or experience.

Furthermore, one can say that there is a parallel between this category and Bandura’s (1989) construct of *self-efficacy*. Bandura (1989, p. 1175) defines perceived self-efficacy as “people’s beliefs about their capabilities to exercise control over events that affect their lives.” Self-efficacy beliefs are thought to function as an important set of proximal determinants of human motivation, affect, and action. Research on self-efficacy beliefs has found that this construct has a direct effect on performance and well-being at work (Bandura, 1999; 2001).

Self-efficacy is also believed to be connected to burnout, especially by writers having a process approach to burnout. Cherniss (1993) views lacking a feeling of competence or perceived efficacy as playing a central role in the burnout process, and argue that factors in the individual or the work situation that enhances feelings of success and competence would reduce burnout, while factors that promote feelings of inadequacy and failure would increase burnout. Leiter (1992) goes even further than Cherniss and consider burnout essentially as “a crisis in self-efficacy.” Evidence for the latter statement has not yet been found in empirical research, but several studies have indeed found that self-efficacy has both direct and moderating effects on the experience of burnout (e.g. Evers, Brouwers, & Tomic, 2002; Salanova, Peiró, & Schaufeli, 2002; Van Yperen, 1998)

### Limitations concerning being too goal oriented

*Being too goal oriented* is the overarching theme in the second broad category described in the result section. The answers in both subcategories of limitations are with few exceptions attributed to different aspects of personality or having certain abilities. Regarding the differentiation of difficulties described by Schröder and Davis (2004), these limitations therefore seem to fall into the category *paradigmatic difficulties*. Schröder and Davis (2004, p. 332) define these difficulties as “difficulties that arise out of the enduring characteristics of the therapist experiencing them.” They further describe them as idiosyncratic, and typical of individual therapists rather than of situations or developmental level. Because of the enduring nature of these difficulties one can interpret these limitations as being limitations the psychotherapist have been experiencing entering their professional role. The enduring nature of these difficulties also implies that acquisition of further skills or accumulation of more clinical experience might not be enough to eliminate them, more comprehensive personal change would be needed to avoid these difficulties. The answers given by the psychotherapist in both subcategories seem to be in line with this; the majority of the respondents reports either having experienced no or negative recent change.

Being a therapist often means that you are an agent of change, and therefore often have specific goal you work towards. The limitations described in both subcategories may be seen as reflecting a *goal directedness*. Being focused on the goals which one is working towards is seen as favourable for both client and therapist (Orlinsky & Rønnestad, 2005). But if the therapist displays an unbalanced focus on the therapeutic goals, and overlooks focusing on the therapeutic relation, the client may feel this as stressful and it might become difficult to openly discuss potential failures in reaching the therapeutic goals. This might also increase the risk of client drop out, potentially increasing the therapist’s feelings not being successful. Being *impatient* or having *the need to see progress* are often manifested through own experiences of *uncertainty and carefulness* and *exhaustion and resignation*. Some of these psychotherapists also report tendencies toward feelings of *disengagement*. Taken together, the manifestation of these limitations may reflect that unbalanced goal directedness also is experienced as stressful for the therapist.

The limitations categorized as *too goal oriented* can further be seen as reflecting a tendency towards *type A behaviour*. “Type A behaviour” is used to describe behavioural patterns combining ambition, competitiveness, time urgency, impatience, and hostility (Hallberg, Johansson, & Schaufeli, 2007). Recent research also indicates that type A behaviour instead of being one global construct, actually include two principal dimensions:

*achievement striving* and *irritability/impatience* (Day & Jreige, 2002). The limitations described in the subcategories *impatience and careflessness* and *the need to see progress* seem to be related to the latter of these two dimensions.

As mentioned in the introduction global type A behaviour are frequently linked to burnout (Maslach et al., 2001; Schaufeli & Enzmann, 1998), and recent research has shown that especially the irritability/impatience dimension is associated with more frequent burnout complaints (Hallberg et al., 2007). Hallsten, Josephson, and Torgén (2005) links type A behaviour to an “anxious engagement”, that is, a negatively charged involvement in work fuelled by a need for approval. In their study they established that individuals using performance at work as a measure of personal value are more vulnerable to burnout, and as such, linking type A behaviour to Hallstens process model of burnout (Hallsten, 1993; Hallsten et al., 2005).

#### Limitations concerning relational difficulties in therapy

*Relational difficulties in therapy* is the third broad category described in the results. The first subcategory, *regulation of emotional distance*, concerns what appears to be enduring patterns of difficult interaction with the clients in therapy. As with the previous categories, the limitations in this category also seem to correspond to what Schröder and Davis (2004) refer to as *paradigmatic difficulties*. Again, one might interpret these limitations as representing more enduring characteristics the psychotherapist also experience prior to entering the therapeutic arena as these limitations are typically attributed to the psychotherapists’ *personality or certain abilities*. The second subcategory, *dysfunctional emotional reactions in therapy*, is somewhat harder to locate in Schröder and Davis’ (2004) differentiation. On the one hand, these limitations do not have a clear manifestation or a typical attribution, but they are frequently associated with *recent positive change*, indicating that these limitations might be of a more *transient* nature. On the other hand, just below half of the psychotherapist in this category attributed these limitations to *internal personal self*, while an exact equal amount of psychotherapist attributed the limitations to *external work conditions*, indicating that these limitations could be seen both as *paradigmatic* and *situational*. But Schröder and Davis (2004) note themselves that even though their categories are described as mutually exclusive, difficult experiences are likely to contain elements of more than one type.

The limitations described in both subcategories seem to refer to tendencies towards having own emotional reactions easily evoked in the therapeutic process without having

constructive ways of handling them. These tendencies seem to refer to what in the literature on therapy research has been called *countertransference*. Since Freud (1910) introduced the concept nearly 100 years ago, numerous definitions of these concept has emerged. A modern definition, known as the integrative conception, defines countertransference as “therapist reactions to clients that are based on the therapist’s unresolved conflicts” (Hayes, 2004). Having these countertransference reactions in therapy are not the issue here per se, in fact, most therapist probably experience these kinds of reactions. As Hayes (2004, p. 24) says: “Therapists of all theoretical persuasions, by virtue of their humanity, have unresolved personal conflicts; try though we might, no professional credentials or experiences shield us from the human condition.” The difficulties arise when the therapist lack the abilities for constructive management of these reactions, as seem to be the case with the psychotherapists categorized as having *relational difficulties in therapy*.

In a qualitative study of 8 seasoned therapists, manifestations of countertransference in the therapist were categorized in four common categories: *approach reactions* that drew the client and therapist closer together; *avoidance reactions* that distance the therapist from the client; *negative feelings* that were uncomfortable and could either increase or decrease the distance between therapist and client; and *treatment planning* which consisted of therapists’ decisions related to the process or course of therapy (Hayes, McCracken, McClanahan, Hill, Harp, & Carozzoni, 1998). A closer look at the limitations concerning *regulation of emotional distance* and *dysfunctional emotional reactions in therapy* and their manifestation shows that the former type of limitations often is manifested as *avoidant behaviour in therapy*, and seems therefore comparable to the second category found in Hayes and colleagues’ (1998) study. The latter type of limitations is most frequently manifested as either *disengagement* or *inadequate structuring of therapy*, which can be interpreted as belonging to Hayes and colleagues’ (1998) second and fourth category, respectively.

The fact that limitations described as *regulation of emotional distance* and *dysfunctional emotional reactions in therapy* are most frequently manifested as *avoidant behaviour in therapy* and *disengagement*, respectively, can also be interpreted to indicate that these therapists do not have adequate *coping strategies* at hand when they encounter stress in the form of relational difficulties in therapy. As described in the introduction coping strategies can be categorized as four different styles: active, inactive, direct, and indirect. The respondents categorized in both subcategories of the broad category *relational difficulties in therapy* seem to have a coping style that could be characterized as *direct-inactive coping* in that they avoid or distance themselves from the source of stress. As also noted in the

introduction, this coping style was what Simioni and Paterson (1997) found to be associated with the highest burnout scores in their study.

#### Limitations concerning basic doubt concerning own qualifications

The fourth broad category of limitations described in the results is *basic doubt concerning own qualifications*. This category is more difficult to locate in Schröder and Davis' (2004) framework. On the one hand, the descriptions of these limitations indicate that they are of a rather enduring nature reflecting that these difficulties are of a *paradigmatic* character. This is further underlined by a frequent attribution of these limitations to *internal personal self*. On the other hand, these limitations are also frequently associated with a *recent positive change*, indicating that these limitations are *transient*. A closer look at the attribution of these recent positive changes reveals that most of these changes are attributed to having own personal therapy. Taken together with the fact that almost half of the psychotherapists in this category report having experience either *no* or *negative recent change*, this indicates that these limitations can be considered as paradigmatic. A third possibility is that these limitations can be viewed as including both *transient* and *paradigmatic difficulties*.

As the limitations is described in this category seem to be closely related to the concept of low *self-esteem*, they might further constructively be discussed in terms of this concept. The literature on self-esteem is extensive. There is, however, a lack of consensus on how best to understand the concept. Different researchers have been focusing on different types of self-esteem as more or less stable (e.g. Deci & Ryan, 1995; Heatherton & Polivy, 1991; Leary, Tambor, Terdal, & Downs, 1995). Deci and Ryan (1995) differentiate between two types of self-esteem; *contingent self-esteem*, which is dependent on matching some important standards or demands, and *true self-esteem*, which refers to “feelings associated with the autonomous or integrated aspect of oneself” (p. 35). The limitations experience by my respondents in the *basic doubt concerning own qualifications* category could be seen as reflecting low levels of both these types of self-esteem. This further might indicate that the respondents expressing limitations reflecting lower contingent self-esteem feel they do not live up to the standards of their role as a professional psychotherapist, and that those respondents reflecting lower levels of true self-esteem feel they are out of tune with their ideal selves.

Another perspective on self-esteem is offered by the sociometer theory (Leary, 2005). The sociometer theory proposes that self-esteem is a part of a psychological system that

monitors people's acceptance and rejection by others, or their relational value. In this perspective self-esteem has no value in its own right. Rather, self-esteem is viewed as the output of a sociometer that monitors and responds to events vis-à-vis interpersonal acceptance and rejection, a system that responds to changes in their social environments (ibid.). Cues indicating that the individual is not adequately valued and accepted by other people lower self-esteem and motivate behaviours that enhance relational evaluation (Leary, 1999). Whether or not the limitations expressed by my respondents in this category also include a fear of rejection is somewhat harder to conclude on.

Lower self-esteem has been related to all three burnout dimensions (Jansen, Schaufeli, & Houkes, 1999; Maslach et al., 2001). Indeed, it has been argued that poor self-esteem, together with low levels of hardiness, an external locus of control, and an avoidant coping style typically constitute a stress-prone individual (Semmer, 1996, in Maslach et al., 2001). The burnout research referred to in the introduction gives evidence supporting this personality profile. But it has been difficult to establish whether poor self-esteem is a cause or consequence of burnout (e.g. Jansen et al., 1999).

#### Limitations concerning difficult work conditions

The last broad category described in the results, *difficult work conditions*, seems related to what Schöder and Davis (2004) refer to as *situational difficulties*. Situational difficulties are defined as “difficulties that are inherent in the situation encountered by the therapist” (ibid., p. 332), and may either arise from problematic circumstances or from patients experienced as problematic. Schöder and Davis further note that these difficulties are not reflective of the therapist's enduring personal characteristics and, although they may be attenuated, they cannot be eliminated through further training and experience. The limitations described by the respondents in this category all seem to refer to external circumstances that are typically associated with either *no* or *negative recent change*. What is somewhat surprising is that these respondents, in addition to *external work conditions*, also frequently attribute these limitations to *personality or certain abilities*. A closer look at what these latter respondents attribute their limitations to give one possible reason for this, in that they refer to personal characteristics that are creating a mismatch between themselves and the work conditions they currently are in. The problems do not seem to lay in either the characteristics of the work conditions or in their personal characteristics per se, rather it is the combination of the two that is causing the difficulties.

The limitations described as *difficult work conditions* seems to be equal to what in introduction was called *organisational characteristics*, i.e. workload and time pressure, role conflict and role ambiguity, and social support to name a few. These work characteristics have been studied frequently in the context of burnout, and it is therefore not surprising to find these elements in this study of burned out psychotherapist. But what is surprising is that in this study very few of the respondents express main limitations of this kind. This broad category is by far the smallest compared to the other broad categories. This can be interpreted to indicate that these burned out psychotherapist are more concerned with limitations and difficulties of more internal personal origins.

### **Theoretical considerations**

As noted above, the burned out psychotherapists in this study seem to express limitations and difficulties with origins of more personal types. If this is to be the case, these findings would be rather contradictive to the view of leading burnout writers, such as Maslach and Leiter (1997). They argue that the causes of burnout lie more in the job environment than in the individual. Maslach and Leiter (1997) have formulated a model of burnout that focuses on the degree of mismatch between the person and six domains of his or her job environment. The first mismatch occurs when the person has an excessive *work overload*. Too many demands exhaust the workers energy, especially emotional work is draining when the job requires the worker to display emotions that are inconsistent with their own feelings. The second mismatch comes from *lack of control*, either having insufficient control over the resources needed to do the work or having insufficient authority to pursue the work in what one believe is the most effective manner. A third mismatch is an *insufficient reward* for the work one do. Sometimes it is insufficient financial reward, but more importantly, according to Maslach and Leiter (ibid.), is the loss of intrinsic satisfaction and social reward. The fourth mismatch concern a *breakdown of community*, or losing sense of positive connection with others in the work. The fifth mismatch is the *absence of fairness* in the workplace, e.g. when there is inequity of workload or pay. Finally, the sixth mismatch concern *conflicting values* at work, such as a discrepancy between organizational values and the workers personal values.

One has to note that some of the categories found in the present study could be interpreted as indicating at least some of these mismatches. For example, having to hide that you are feeling impatient, afraid, or irritated as the respondents who have been categorized as

*too goal oriented* and *having relational difficulties in therapy* say they often are, might be interpreted as Maslach and Leiter's (1997) first mismatch, an excessive *work overload*. In similar fashion, experiencing a *lack of professional efficacy* might be interpreted as really being about experiencing *lack of control*, the second mismatch. Of course, environmental characteristics or mismatches may still have an influence on these therapists, only they are hidden from our view in this study. Nevertheless, these psychotherapists seem to be more concerned with limitations and difficulties originating from causes within themselves, and from the respondents' subjective view, work or environmental characteristics seem not to be the main issues.

The largest and most distinct broad categories in this study were *lack of professional efficacy*, *relational difficulties in therapy*, and *basic doubts concerning own qualifications*. These broad categories have been discussed in light of concepts such as self-efficacy, countertransference and coping strategies, and low self-esteem. If one takes a step back and look at the bigger picture – one underlying theme seems to stand out, namely that these psychotherapists are expressing *feelings of incompetence*. In the study referred to in the introduction, Thériault and Gazzola (2005) found three different categories of feelings of incompetence (FOI) that differed along a continuum of intensity. Their three categories of FOIs seem to be comparable to the three central broad categories in present study. *Lack of professional efficacy* seems to be corresponding to the category labelled *inadequacy* by Thériault and Gazzola (2005), which, in their study, usually resulted from professional issues such as questioning one's knowledge, skills, training, and ability to help the client on a general level. In similar vein, the broad category *relational difficulties in therapy* in present study seems to be a parallel to Thériault and Gazzola's category *insecurity*, which was feelings related to therapist self-confidence in their professional roles and also spoke about their faith in the process of therapy. These self-doubts were more disturbing and more difficult to assimilate and accept, and often stemmed from relationship issues and communication obstacles. Finally, Thériault and Gazzola's last category of feelings of incompetence, *incompetence proper*, were the most intense, uncomfortable, and damaging forms of FOI. These feelings arose from personal issues, and the nature of the self-doubts often targeted core elements of the self. Major themes that represented these self-doubts were contribution/attribution and identity issues. This last category seems to match the broad category labelled *basic doubts on own qualifications* found in the present study.

In sum, the respondents in the present study seem to be expressing feelings of incompetence of different intensity levels, that is, expressing difficulties that have their origin



more within the respondents and less in the work environment in which they work. This argument is further underlined by to what the respondents attribute their main limitations; of the 60 psychotherapists in the strategic sample, 42 of them (70%) attributed their main limitation to internal personal self.

One way of shedding light on these findings is through Hallsten's conception of burnout as a process of failing self-esteem strivings into psychic strain and distress (Hallsten, Josephson, & Torgén, 2005). In this conception, burnout becomes more of a cognitive and motivational process than just a stress process. Burnout is supposed to occur only in activities with a potential for self-expression or self-definition. Considering that the psychotherapists in this study have gone through at least six years of education before becoming a psychotherapist, many of them with additional training and years of work experience after that, one might assume that being a psychotherapist constitute a self-definitional role for most of these therapists. In fact, research has shown that many therapists enter their professional role with high aspirations for their functioning and a desire to excel in their work (Skovholt & Rønnestad, 2003). Hallstens further note that burnout does not refer to a syndrome of psychic strain-distress and crisis, but to a mediating process of self-esteem strivings into this syndrome, occurring when the enactment of a self-definitional role is threatened or obstructed by an incongruent environment with enduring or recurrent stressors (Hallsten et al., 2005). The initial phase of this process is called "Anxious engagement". This phase is characterised by high involvement and engagement but also signs of concern and anxiety. This phase may turn over into "Frustration striving", characterised by feelings of being obstructed from attaining goals, cognitions of lost control and powerlessness, recycling coping efforts, and approach and avoidance strivings (Hallsten, 1993; Hallsten et al., 2005). Hallsten (1993) note that, even though this is perhaps the most distressing part of the burning-out process, people seems to be able to live with this heroic attitude for years. But eventually, in case of exposure to unmanageable recurring or chronic stressors this turns into the "Burnout"-phase. This phase is assumed to occur after additional experiences of defeat or reduced functional capacity.

The driving force in this process is what Hallsten (et al., 2005) calls "performance-based self-esteem". Performance-based self-esteem is defined as "a psychological construct of interrelated cognitions, emotions and motives arising as a response to chronic or recurring stressors, appraised as challenges or threats to self-worth and self-esteem" (ibid. p. 5). This construct does not describe a certain level of self-esteem, but indicates how self-esteem is shaped and maintained. It refers to one type of contingent self-esteem (Deci & Ryan, 1995), and is introduced in the process model to give a plausible explanation for the alleged

transition from high involvement into strain, distress and disinterest in the burnout process (Schaufeli & Enzmann, 1998). In this process model of burnout performance-based self-esteem constitutes a vulnerability factor for high psychic strain and distress (Hallsten et al., 2005)

Returning to the categories in the present study, interpreted above as indications of feeling of incompetence (FOI; Thériault and Gazzola, 2005), these might be seen as an expression of this performance-based self-esteem evoked by the threat these FOIs pose to the respondents self-definitional roles as professional psychotherapist. The different intensity level of these FOIs expressed by the respondents in the present study might be interpreted as an indication of how far these psychotherapists have come in the burnout process. Following this argument, one might be most concerned about the psychotherapist who are expressing *basic doubt concerning own qualifications*, as they express FOIs of the most intense, uncomfortable, and damaging type. According to Hallsten's (1993; et al., 2005) process model of burnout, these psychotherapist might be standing in the entrance to depression. On the other hand, Hallsten (1993) further note that both the burning-out and depression processes may eventually result in more sudden, positive changes. Indications of this are seen in the psychotherapist reporting having own personal therapy.

### **Limitations of the study**

Some possible limitations are connected to the material being analysed in this study. Although the sample in the present study is quite large for a qualitative study, the individual respondent's answers are rather short, resulting in a not too extensive material. Although the short answers makes the individual experience of each therapist less accessible, this may be a good basis for studying a phenomenon. But if one wants to reveal more of the experiences of individual therapists' an interview method would have been a better approach.

One might also question whether using an extended questionnaire addressing several different topics is the best way of gathering information about one single phenomenon. It might be that a specific questionnaire or an interview addressing only the phenomenon being studied would have provided a richer material. On the other hand, since the topics under investigation in this study are of a potentially sensitive nature to the therapists one might imagine that using a questionnaire and the anonymity connected to this may have served to reduce the possibility of socially desirable answers.

Finally, it has to be noted that not all the respondents in this strategic sample have burnout scores that are particularly high. The reason for this is, most likely, that, as a group, psychotherapists are not very burned out. Even so, the psychotherapists included in the sample represent the extreme group of these psychotherapists. Of the entire population of clinical psychologist working as a psychotherapist, these are the once who are the most burned out, and, therefore, are justified as being the focus of this study.

### **Conclusions and implications**

The current study has shown that burned out psychotherapist have a diverse experience of main limitations as therapists. However, some patterns are more distinct. Main limitations seem to concern experiencing lack of professional efficacy, being to goal oriented, relational difficulties in therapy, having basic doubts concerning own qualifications, and experiencing work conditions as difficult. The major attribution of these limitations was to reasons associated with internal personal self.

Research has to a large degree been focused on work or environmental variables in the search for the cause of burnout. This study implies that internal personal characteristics are major contributors in the process of burning out, suggesting the need for future research to also focus on how personal vulnerability contributes to the process of burning out. Conceiving burnout as a process of self-esteem strivings into psychic strain and distress implies that burnout is not only a stress process but also a cognitive and motivational process.

The burned out psychotherapists in this study describe difficult personal feelings in therapy, relational problems, and feelings of incompetence. A natural further step would be to study how these therapists are viewed by their clients and how these difficulties are connected with the outcome of therapy.

Several of the psychotherapist describing basic doubt concerning own qualifications report a recent positive change due to own personal therapy. This implies a possible way out of the burnout process. This may be an important reminder to the professionals of the need for personal therapy and supervision in order to maintain an adequate function as a psychotherapist.

**APPENDIX A: Table 1: Individual summaries based on categories of limitations**

<b>Limitation</b>	<b>Manifestation</b>	<b>Attribution</b>	<b>Recent change and attribution</b>
<b>I. Lack of professional Efficacy</b> <i>1. Experience</i>	Own experience <i>Uncertainty**</i> Problems therapeutic work <i>Inadequate structuring</i>	Internal professional self (#) Internal personal self: <i>Personality/abilities</i>	NO* Positive
<i>2. Knowledge/skills</i>	Own experience <i>Uncertainty</i> <i>Exhaustion/Resignation*</i> Problems therapeutic work <i>Inadequate structuring**</i>	Internal professional self Internal personal self (#) <i>Personality/abilities</i> <i>Experience</i> External work conditions	NO Positive**
<i>3. Structure</i>	Own experience <i>Uncertainty</i> <i>Exhaustion/Resignation</i> Problems therapeutic work <i>Inadequate structuring</i>	Internal professional self Internal personal self (#) <i>Personality/abilities**</i> <i>Experience</i> External work conditions	NO* Positive** Negative*
<b>II. Being too goal oriented</b> <i>1. Impatience</i>	Own experience <i>Exhaustion/Resignation</i> <i>Disengagement</i> Problems therapeutic work <i>Inadequate structuring*</i>	Internal personal self (#) <i>Personality/abilities**</i> External work conditions	NO Positive Negative
<i>2. Need to see progress</i>	Own experience <i>Uncertainty**</i> <i>Exhaustion/Resignation*</i> <i>Disengagement*</i>	Internal personal self (#) <i>Personality/abilities**</i>	Negative**
<b>III. Relational difficulties</b> <i>1. Emotional distance</i>	Own experience <i>Exhaustion/Resignation</i> <i>Disengagement*</i> Problems therapeutic work <i>Inadequate structuring*</i> <i>Avoidant**</i>	Internal professional self* Internal personal self (#) <i>Personality/abilities**</i> <i>Experience*</i>	NO Positive Negative
<i>2. Dysfunctional emotions</i>	Own experience <i>Exhaustion/Resignation*</i> <i>Disengagement</i> Problems therapeutic work <i>Inadequate structuring</i> <i>Avoidant*</i>	Internal personal self <i>Personality/abilities*</i> <i>Experience</i> External work conditions	NO* Positive** Negative*
<b>IV. Basic doubt concerning own qualifications</b>	Own experience <i>Uncertainty</i> <i>Exhaustion/Resignation</i> <i>Disengagement</i> Problems therapeutic work <i>Inadequate structuring</i> <i>Avoidant</i>	Internal professional self Internal personal self (#) <i>Personality/abilities</i> <i>Experience</i> External work conditions	NO Positive** Negative
<b>V. Difficult work conditions</b>	Own experience <i>Uncertainty**</i> <i>Exhaustion/Resignation*</i>	Internal professional self* Internal personal self (#) <i>Personality/abilities**</i> External work conditions	NO* Negative

\* Indicating only one answer being categorized in this manner.

\*\* Indicating half or more of the answers categorized in this manner.

(#) Indicating half or more of the answers categorized in this broad category

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